Maya Heffernan, MA
Licensed Marriage and Family Therapist 11163
3990 Old Town Avenue, Suite B100, San Diego CA 92110
Phone: 619-277-1930

Maya Heffernan, LMFT

Minor Intake Form

Personal Information		
Minor's Name:	Age:	DOB:
Address:		
Home Phone: OK to leave message? ☐Yes ☐No		
Cell Phone: OK to leave message? ☐Yes ☐No		
Email: OK to email you? ☐Yes ☐No **Please note: email and text correspondence is not considered to be a confidential medium of communication**		
My Therapist may identify him/herself when calling ☐Yes ☐No		
What is your child's current grade in school?		
Has he/she ever repeated a grade? ☐Yes ☐No		
What school does your child attend?		
Does your child have an IEP? ☐Yes ☐No		
How did you hear about Maya Heffernan LMFT? ☐Web search ☐Friend ☐Church ☐Former Client ☐Other		
Name of referral: May I thank this person? ☐Yes ☐No		

Parent Information **This parent will be used as child's emergency contact**	
Name:	
Address:	
Cell Ph:	Home Ph:
Child's parents are (choose one): ☐Married ☐Separated ☐Divorced ☐Living Together	
If separated or divorced, how old was your child when separation occurred?	
Child lives with (choose one): ☐Both parents ☐Mother ☐Father ☐Other:	
Who has legal custody of minor?	

Health and Medical History	
List any major illnesses:	
List medications your child is curently taking and purpose of each:	
Name of child's primary care physician:	
When was your child's last physical exam?	

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Is your child currently under the care of a psychiatrist? ☐Yes ☐No

If yes, what is name of psychiatrist?

If yes, what are you being treated for?

Has your child previously seen a therapist? ☐Yes ☐No

If yes, what year?	About how many meetings did your child have?

What was the reason for therapy?

Was the experience helpful or not? How so?

Has your child ever beeen hospitalized for a medical or mental illness? ☐Yes ☐No
If so, list when, where, and reason:

Has your child ever had thoughts of ending his/her life? ☐Yes ☐No
If yes, please explain circumstances:

Has your child ever attempted to end their life? ☐Yes ☐No
If yes, please explain circumstances (when, how, what treatment he/she received):

Has your child been treated for any of the following?

☐Head injury/loss of consciousness	☐Frequent ear infections	☐Tubes placed in ears	☐Hearing or vision problems	☐Headaches
☐Meningitis	☐Seizures	☐Asthma	☐Elevated lead levels	☐Allergies
☐Speech problems	☐Learning problems	☐Cancer	☐Surgeries of any kind	☐Trauma
☐Mood disorder (ie depression	☐Anxiety	☐Panic attacks	☐ADHD/ADD	☐Eating disorder
☐Substance use	☐Self-harm or self-injurious behavior	☐Other		

Do you believe your child drinks alcohol or uses recreational drugs? ☐Yes ☐No
If yes, what kind and how often?

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Family/Developmental History		
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?		
Depression ☐Yes ☐No	Bipolar Disorder ☐Yes ☐No	Anxiety Disorder ☐Yes ☐No
Schizophrenia ☐Yes ☐No	Alcohol/Substance Abuse ☐Yes ☐No	Eating Disorders ☐Yes ☐No
Trauma History ☐Yes ☐No	Suicide Attempts ☐Yes ☐No	Domestic Violence ☐Yes ☐No
Panic Attacks ☐Yes ☐No	Learning Disabilities ☐Yes ☐No	
Please list your child's brothers and sisters and age of each:		
Were there any complications during pregnancy or delivery? ☐Yes ☐No If so, please describe:		
Has your child experienced or witnessed any abuse? ☐Yes ☐No If yes: ☐Physical ☐Verbal ☐Emotional ☐Sexual		
Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? ☐Yes ☐No If yes, please explain:		
What are 5 things you enjoy most about your child?		
What is the main reason(s) you are seeking help for your child? *Please include how long he/she has had these symptoms*.		
What are your hopes regarding your child's therapy?		

_____ _____

Parent Signature Date